

NOTICE OF INDEPENDENT REVIEW DECISION

March 3, 2003

RE: MDR Tracking #: M2-02-1159-01
IRO Certificate #: IRO 4326

The ____ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ____ physician reviewer who is board certified in anesthesiology which is the same specialty as the treating physician. The ____ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ____ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 30 year old female sustained a work-related injury on ____ when she bent over to pick up a part from a shelf and felt a pop in her back. The patient received chiropractic care, physician care, an MRI, physical therapy, hot and cold packs, x-rays and injections. The patient continues to complain of lower back pain that radiates down the left leg to the left foot. After evaluation at the ____, the treating physician is recommending that the patient undergo a pain management program for 30 days.

Requested Service(s)

Pain management program for 30 days.

Decision

It is determined that the pain management program for 30 days is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has had pain since an injury in ____ and has developed psychological traits of chronic pain syndrome. The patient is in the tertiary phase of specialized care. A psychological evaluation reveals traits such as poor coping, sleep disturbance, anxiety, depression, and decreased activity. Evidence based approaches to this kind of chronic pain patient show best response from a treatment with a 20 day multidisciplinary pain program as long as the patient continues to meet goals throughout the program. In the case of this patient, a 30 day program is appropriate as long as the patient is achieving goals. One of the goals of the pain program is to address the issues, which are hindering vocational rehabilitation. Therefore, this treatment is especially appropriate for this worker's compensation patient. The pain management program for 30 days is medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,

cc: Rosalinda Lopez, Program Administrator, Medical Review Division, TWCC

In accordance with Commission Rule 102.4 (h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 3rd day of March 2003.
